Long-Term Care Ombudsman Report FY 2001

Administration on Aging
Department of Health and Human Services

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Note: Additional data are available on the Administration of Aging web site: www.aoa.gov;select Elders and Families then Ombudsman

FY 2001 Long Term Care Ombudsman Report
With Comparisons of National Data for FY 1998-2001

Introduction

This report is submitted in compliance with Section 207(b) of the Older Americans Act of 1965 (OAA), as amended, which requires the Assistant Secretary for Aging to compile a report on information submitted by the states on activities of state long-term care ombudsman programs and provide the report to the congressional committees with jurisdiction over the OAA.

The data and other information presented and analyzed in this report are collected annually by AoA from state ombudsmen under the National Ombudsmen Reporting System (NORS). The data gathered and reported by the states are based on detailed data specifications established by AoA and ombudsman representatives across the country. AoA and state and local ombudsmen pay close attention to assuring that the statistical information reported under NORS is consistent. To further foster consistency in data collection and reporting, AoA addresses data issues annually in its national ombudsman conference, and has established a detailed ongoing action plan to ensure that ombudsmen across the country are continuously trained regarding the NORS definitions and concepts. AoA staff and contractors perform extensive verification and validation checks on the data submitted by ombudsmen prior to data dissemination and publication in reports such as this. Information obtained under NORS also includes narrative presentations by state ombudsmen who provide descriptions of the "priority long-term care issues" which their programs identified and worked on during the reporting period. Because of the nature of the form of reporting utilized, the information reflects the subjective views of the state ombudsmen which submit the reports. This information is summarized in the report.

This report provides data for fiscal year (FY) 2001 from all state ombudsman programs on the activities of those who participate in the Ombudsman Program at the state and local levels, and analyzes changes in the data since FY 1998, the date of the last report. The data from FY 2001 are the most current available. The central observation to be made from the data presented in the report is the significant increase in program activity over a three-year period, reflecting greater use of the Ombudsman Program by residents of long-term care facilities, their relatives, and by those who operate and work in those facilities. The following items illustrate this observation.

- Ombudsmen provided 35% more consultations to individuals in FY 2001 than they provided in FY 1998.
- Ombudsmen provided 58% more consultations to facility staff in FY 2001 than they provided in FY 1998.
- Ombudsmen responded to 35% more complaints in FY 2001 than in FY 1998.
- Ombudsmen resolved 77% of the complaints they handled in FY 2001, compared to 71% in FY 1998.

Long-term care ombudsmen are advocates for residents of long-term care facilities. They work to resolve individuals' problems with care and conditions, and to bring about changes at the local, state and national levels to improve care for all facility residents. Established under Section 712 of the Older Americans Act (OAA), ombudsman programs in every state and 596

local or regional areas carry out a variety of activities to assist residents to maintain a good quality of life and care in nursing homes, assisted living facilities, and other types of long-term care settings. Thousands of trained paid and volunteer ombudsmen provide an on-going presence in long-term care facilities, monitoring care and conditions and providing a voice for residents and their families.

Ombudsman responsibilities outlined in Title VII of the OAA include:

- identify, investigate and resolve complaints made by or on behalf of residents;
- provide information to residents about long-term care services;
- represent the interests of residents before governmental agencies and seek administrative, legal and other remedies to protect residents;
- analyze, comment on and recommend changes in laws and regulations pertaining to the health, safety, welfare and rights of residents;
- educate and inform consumers and the general public regarding issues and concerns related to long-term care and facilitate public comment on laws, regulations, policies and actions;
- promote the development of citizen organizations to participate in the program; and
- provide technical support for the development of resident and family councils to protect the well-being and rights of residents.

The National Long-Term Care Ombudsman Resource Center, operated by the National Citizens' Coalition for Nursing Home Reform in conjunction with the National Association of State Units on Aging, provides on-call technical assistance and intensive training to assist ombudsmen in their demanding work. The Center is supported with funds appropriated by Congress and awarded by the Administration on Aging (AoA).

Report Highlights

Staffing, Providing Support to Volunteers and Local Programs

- There were 596 local and regional ombudsman programs in FY 2001. Most of these programs were located in area agencies on aging.

- The number of paid ombudsman staff increased from 927 full-time equivalents (FTEs) in FY 1998 to 1,029 FTEs in FY 2001.

- In 2001, there were 8,442 ombudsman volunteers certified to investigate complaints. Another 5,258 non-certified volunteers also served the program, for a total of about 13,700 volunteers nationwide in FY 2001.

- Providing technical assistance and training to paid and volunteer ombudsmen is a significant function of state-level ombudsman program staff. In 26 state entities, the program staff spent 30 percent or more of their time providing technical assistance to

volunteers and local programs. In the remaining 30 state entities, program staff used 20 percent or more of their time supporting and training ombudsmen.

- In FY 2001, ombudsman program staff provided or arranged for over 10,000 training sessions, totaling 46,050 hours, to their volunteers and staff.

Ombudsman Presence in Facilities and Empowerment of Families and Residents

- Ombudsman staff and volunteers visited over 85 percent of nursing homes on a regular basis, which is defined as at least quarterly and not in response to a complaint. In 20 states, ombudsmen regularly visited 100 percent of nursing homes; in another ten states, ombudsmen regularly visited 95 or more percent of the nursing homes in their state.

- Nationwide, ombudsman staff and volunteers visited over 44 percent of board and care and similar homes on a regular basis, not in response to a complaint. In 11 states, ombudsmen regularly visited 100 percent of these types of homes.

- In addition to their work on complaints, ombudsmen provided about 283,000 consultations to individuals in 2001. This was an increase of almost 16 percent over the previous year and 35 percent since FY 1998. The most frequent topics of consultation included: how to select and pay for a nursing home, residents rights and federal and state facility rules and policies.

- Ombudsman activity in long-term care facilities provides them with information that can be useful to facility managers and staff. Reflecting this phenomenon, ombudsmen provided 107,602 consultations to facility staff in FY 2001, a 58 percent increase over FY 1998. Consultations can address a wide range of issues, such residents' rights, observations about care issues, and transfer and discharge issues.

- In FY 2001, ombudsmen nationwide also:

  - met with resident councils (14,895 sessions) and family councils (4,317 sessions),
  - provided 8,499 training sessions to facility staff,
  - provided 8,995 community education sessions, and
  - participated in 10,003 facility surveys.

Services to Individuals (complaint investigation and resolution)

- In FY 2001, ombudsmen resolved or partially resolved 78 percent of nursing home complaints and 73 percent of board and care complaints to the satisfaction of the resident or complainant. The combined resolution rate of 77 percent for all facilities compares favorably with the 71% rate last reported for FY 1998.

- Ombudsmen nationwide opened 160,927 cases and closed 151,737 cases involving 264,269 individual complaints in FY 2001.

- From 2000 to 2001, there was an eight percent increase in cases opened, an 11 percent increase in cases closed, and a 14 percent increase in complaints.

- Seventy-nine percent of cases handled were associated with nursing home settings. The remaining 21 percent involved other settings, including board and care facilities, assisted living and other settings.

- Most cases were initiated by residents or friends and relatives of residents.

- Since 1998, there was a 28 percent increase in complaints handled by ombudsmen in nursing homes and a 45 percent increase in complaints handled involving board and care-type facilities.

- The top five nursing home complaints were about *call-light responses, staff attitudes, care plans, accidents and patient handling, and hygiene care.*

- The top five board and care and similar facilities complaints were about *menu quality, medication management, lack of respect for residents, discharge/eviction, and equipment/building disrepair.*

Long-Term Care Issues Addressed by State Ombudsmen

- State-level ombudsmen in 28 states spent at least 20 percent of their time meeting their statutorily mandated responsibility to analyze, comment on, monitor, and recommend changes to federal, state, and local laws, regulations, policies, and actions. Local ombudsmen in 17 states spent ten percent or more or their time on these activities.

- In response to OAA requirements and AoA instructions to "describe the long-term care issues which your program identified and/or worked on during the reporting year," insufficient numbers of staff to care for residents was the long-term care issue most frequently identified by state ombudsmen in their FY 2001 reports.

- Other issues which state ombudsmen frequently worked on their states included: discharge and transfer issues, lack of access to appropriate services or settings, inadequate regulation of assisted living and other non-nursing home facilities, and increased support of the Ombudsman Program.

Experiences of Ombudsmen

In FY 2001, ombudsmen resolved or partially resolved 77 percent of all complaints to the

satisfaction of the resident or complainant. The following cases illustrate how ombudsmen fulfilled this responsibility to assist residents and their families resolve individual problems.

- A California ombudsman helped relocate a woman from a personal care home where she had been neglected and abused by the care giver and abused by foster children living at the home. The woman was placed in a home where she received good care and was reunited with a guardian from whom she had been separated for years. Authorities investigated the care giver of the first home for operating without a current license and poor care of the foster children.

- A Colorado volunteer ombudsman assisted a group of personal care boarding home residents, who had complained to her about conditions in the facility and were being intimidated by the owner as a result, to present their grievances to the licensing agency, which cited the facility for numerous deficiencies. The director of the home resigned, and the residents expressed their relief and gratitude to the ombudsman and were more aware of their rights and how to protect them as a result of their action.

- The Connecticut ombudsman assisted a Medicaid-eligible resident who was being evicted from a Medicaid-certified nursing home because her rehabilitation paid for by Medicare was completed and she had been told upon admission that the facility provided "short term care only." However, she still required nursing home care was not able to return home. The ombudsman explained to the family that the resident would be able to remain at the facility because she still needed nursing home care, which was covered by Medicaid. Sixteen other residents had been moved out of the facility in a similar way. The facility was cited for inappropriate practices, waiting list law violation, inappropriate discharge planning and violation of resident rights; and the case was referred to the Attorney General for further action against the facility.

- The Georgia ombudsman assisted a family to recover over $12,000 for payments they had made for their mother's nursing home care. Due to changes in Medicaid rules, the Medicaid agency had owed them this amount for many months but had not paid them due to bureaucratic tangles.

- The Hawaii ombudsman visited with a man whose sister, who was his guardian, had persuaded his physician to discontinue dialysis treatment because, she said, "he was going to die anyway." The ombudsman discussed the consequences of not receiving dialysis with the resident and then asked him: "Do you want to die?" He said, "No, I want to live." The resident said he wanted the dialysis but was fearful that he would upset his sister. The ombudsman told him that he must express his wishes, helped him talk with his sister and assisted him in having the guardianship removed. The resident continued dialysis – and his relationship with his sister.

- The Massachusetts ombudsman received a call from the son of a newly-admitted resident

in a specialized dementia unit of a nursing home. The home had transferred his mother to a psychiatric facility because she had become agitated and struck out against her caregivers. Ombudsman staff intervened and arranged for a family meeting with facility staff, during which it was learned that the episode which led to the transfer was preceded by the staff's attempt to give the resident a shower. The son had told the facility on admission that the resident was frightened by the shower (not unusual for many dementia residents) and was more amendable to baths. As a result of ombudsman intervention, the woman was returned to the nursing home, where she was given baths as part of her regular care plan. There were no further lashing-out episodes.

- In Mississippi, a nursing aide left an incapacitated woman sitting in a rocking chair for four hours, dressed only in her underwear. The aide admitted she had left the woman, explaining that there were not enough staff on duty to care for all the residents who needed help. The ombudsman reported the problem to the licensing and certification agency, which failed to adequately investigate. When the ombudsman said she would notify the federal regulatory agency of conditions at the facility, the state agency cited the facility for deficiencies, and the staffing level and resident care improved.

- The daughter and legal guardian of a Montana nursing home resident insisted that her mother be tube-fed, but the mother wished to eat. After determining the resident's wishes, the ombudsman and facility social worker assisted the resident to revoke the guardianship. The daughter became threatening to her mother, secured a lawyer to file for guardianship and threatened the doctor with a lawsuit if the tube was removed. The ombudsman continued to provide the resident with support and encouragement. The doctor concurred that the resident had capacity to make these decisions, and the feeding tube was removed, after which time the resident ate well, lost no weight and felt good about making her own decision. The downside was that the daughter did not visit her mom for months following this occurrence.

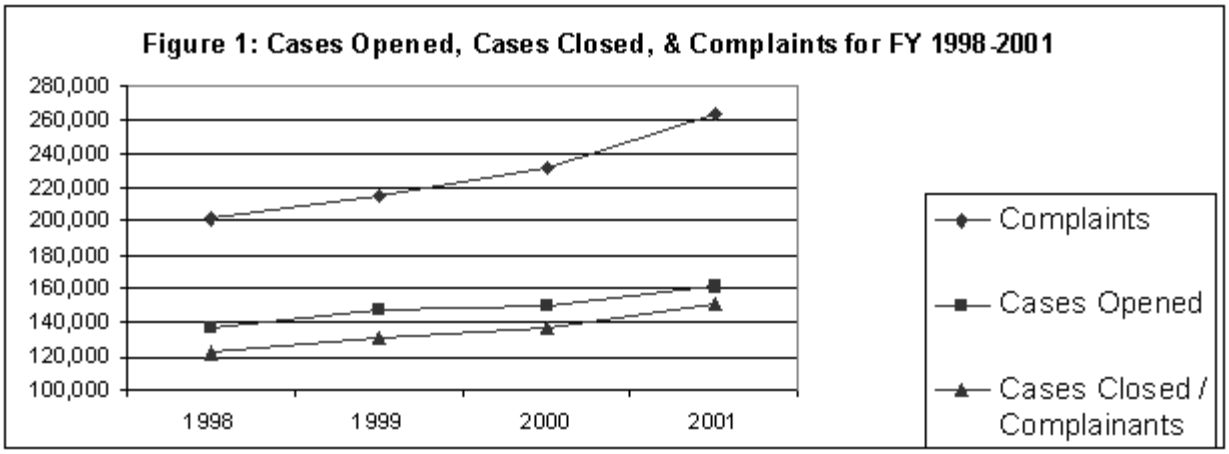
- A resident was discharged from a rural Texas facility where there was only one nursing facility and the closest neighboring facility was approximately 30 miles away. The facility was able to care for the resident but was discharging her due to actions on the part of family members, who the facility perceived as being demanding and displeased with the care provided by the facility. The Ombudsman Program supported the family in appealing the discharge notice, which was a very brief two-sentence statement that did not conform to state standards. The subsequent hearing resulted in a decision to overturn the discharge notice and to allow the resident to remain in the facility close to her family members. Had it not been for the ombudsman intervention, this resident, like many others in Texas, would have been discharged, and the family would have had to look elsewhere for care resources.

Cases and Complaints: FY 2001

Each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or a group of residents is defined as a case. Each case may involve one or more problems, which are referred to as complaints. Except for reporting on the number of cases opened, all data submitted by the states in their annual reports to AoA are for closed cases.

In FY 2001 ombudsmen opened 160,927 new cases and closed 151,737 cases, involving 264,269 complaints[1]. Figure 1 presents the data for FY 1998-2001 in cases opened and closed and in complaints associated with cases closed. There was an 18 percent increase in *cases* opened from 1998 to 2001 and an eight percent increase from 2000 to 2001. There was a seven to eight percent increase in *complaints* each year from 1998 to 2000, with a 14 percent increase from 2000 to 2001. The number of closed *cases* increased 11 percent from 2000 to 2001, five percent from 1999 to 2000 and seven percent from 1998 to 1999.

As shown in Figure 2, most complaints that were closed were filed by residents of facilities or by



friends or relatives of residents. In every year since 1998 there was an increase in percentage of complaints filed by residents, with that category eventually accounting for over a third of all complainants. There was a corresponding drop in percentage of complaints initiated by friends or relatives of residents during that time period and yet they still accounted for almost a quarter of all cases in 2001. Although it is difficult to draw conclusions from data such as these, it appears to be a positive indicator that residents themselves are increasingly using the services of Ombudsmen. The next highest groups filing complaints for all three years were ombudsmen and facility managers and staff.

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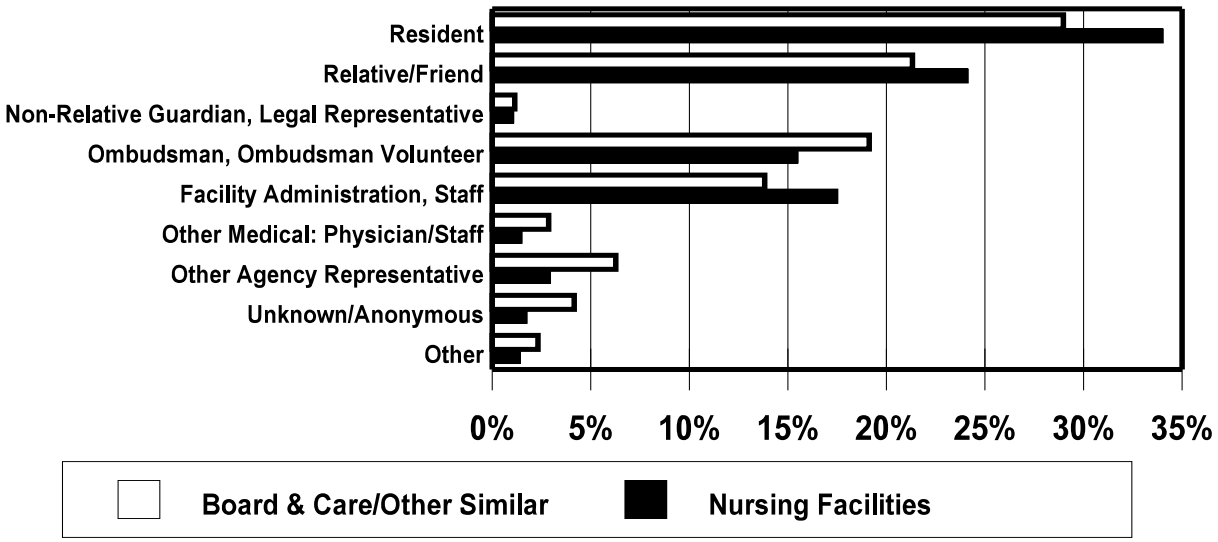
Figure 2: Types of Complainants for Cases Closed FY 2001



The five most frequent nursing home complaints concerned:

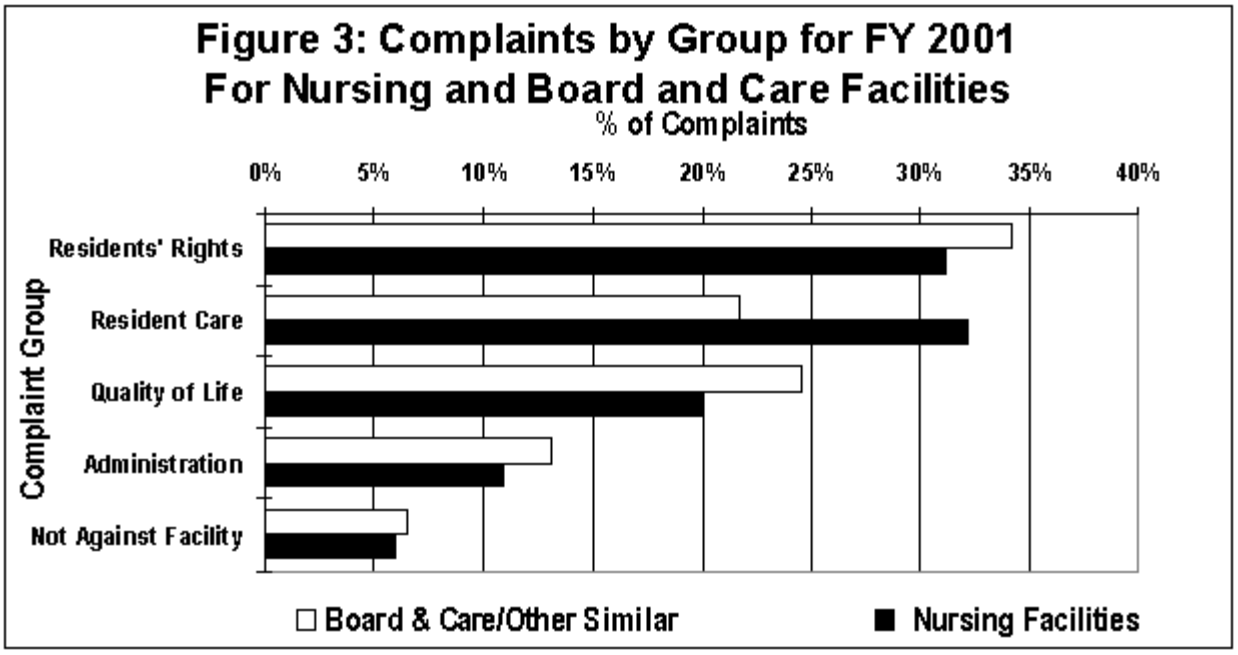
- unheeded responses to call lights, requests for assistance;
- lack of respect for residents, poor staff attitudes;
- problems with care planning and resident assessment;
- improper handling and accidents; and
- neglected personal hygiene.

The five most frequent complaints involving board and care, assisted living and similar facilities concerned:

- quality, quantity, variation and choice of food;
- medications - administration, organization;
- lack of respect for residents, poor staff attitudes;
- inadequate or no discharge/eviction notice or planning; and
- equipment or building hazards.

As illustrated in Figure 3, complaints about rights, care and quality of life constitute the major categories of problems addressed by Ombudsmen in nursing homes and in board and care facilities.

As shown in Table 4 on page 16, since 1998 the percent of complaints resolved or partially resolved to the satisfaction of the resident or complainant increased from 71 percent to 77 percent. In 2001 this figure was 78 percent for nursing homes, 73.3 percent for board and care homes and 76.7 percent for all settings, as illustrated in Figure 4 below. In 2001, 75.3 percent of all



complaints were verified.[2]

A four-year comparison of the top 20 specific nursing home complaints (Table 5 on page 17) indicates that the same care issues continued to dominate the top ranks from 1998 to 2001. In fact, the only change in the top five complaint categories was that by 2001 they accounted for an even larger proportion of the total complaints — from 18.6 percent in 1998 to over 20.5 percent in 2001.

The top five complaints for board and care, assisted living, and similar facilities – *menu quality, variation and choice* (J71), *medication administration and organization* (F44), *dignity, respect and staff attitudes* (D26), *lack of adequate discharge/eviction planning* (C19), and *equipment or building problems* (K79) – were virtually the same for the four years from 1998 to 2001. (See Table 6 on page 18, which shows the top 20 complaints.)

Other Ombudsman Activities in Addition to Complaint Work

Ombudsmen perform numerous functions in addition to investigating and resolving complaints. These include visiting facilities on a regular basis (not in response to complaints), participating in facility surveys conducted by state regulatory agencies, working with resident and family councils, providing community education, working with the media, training ombudsman staff and volunteers, training and consulting with managers and staff of long-term care facilities, and providing information and consultation to individuals. In addition to these activities, ombudsmen also monitor and work on laws, regulations, and government policies and actions.

These activities are listed in Table 12 on page 21, with national totals measuring the extent of ombudsman work on each of the activities, nationwide, for 1998-2001. As the data indicate, the ombudsman programs generally increased nursing facility visitation almost every year from 1998 to 2001, and in 2001 the percentage of these facilities visited regularly (not in response to complaints) rose to 85.4 percent. Visitation to board and care facilities remained around 44.5 percent since 1998, despite increases in numbers of beds and facilities.

There have been significant increases in consultations to individuals. In 2001, ombudsmen provided about 283,000 consultations to individuals on such topics as facility selection, residents rights and benefits, and long-term care facility regulations and policies. This was an increase of over 35 percent compared to the 209,476 reported for FY 1998.

Other ombudsman activities in 2001 directly related to consumer or resident and family empowerment include participation in 8,995 community education sessions, 14,895 meetings with family councils and 8,995 meetings with resident councils. These were all consistent with activity levels in past years.

In facility-related activities that also directly support residents and families, *ombudsman consultations to facilities increased over 58 percent since 1998,* rising from 68,066 to 107,602 in FY 2001.

Ombudsmen also participated in 8,499 sessions to train facility staff and participated in 10,003 facility surveys in 2001. The levels of both of these activities were comparable with activity levels in earlier years.

The number of ombudsman staff and volunteer participants receiving training arranged by the Ombudsman Program increased 74 percent, from 30,717 in 1998 to 53,591 in 2001. On average, each ombudsman staff and volunteer participated in three to four sessions in FY 2001. For 2001, state ombudsmen reported arranging for 10,001 training sessions for groups of ombudsmen and 46,050 training hours (for groups) These levels were similar to what was provided in prior years.

Ombudsman work with the media in 2001 fluctuated considerably from year to year because of changing circumstances. The 2001 figures of 5,811 interviews and 4,388 press releases were consistent with a typical year.

Ombudsman work on laws, regulations and government policies and actions is referred to as issues advocacy, which is discussed in the next section.

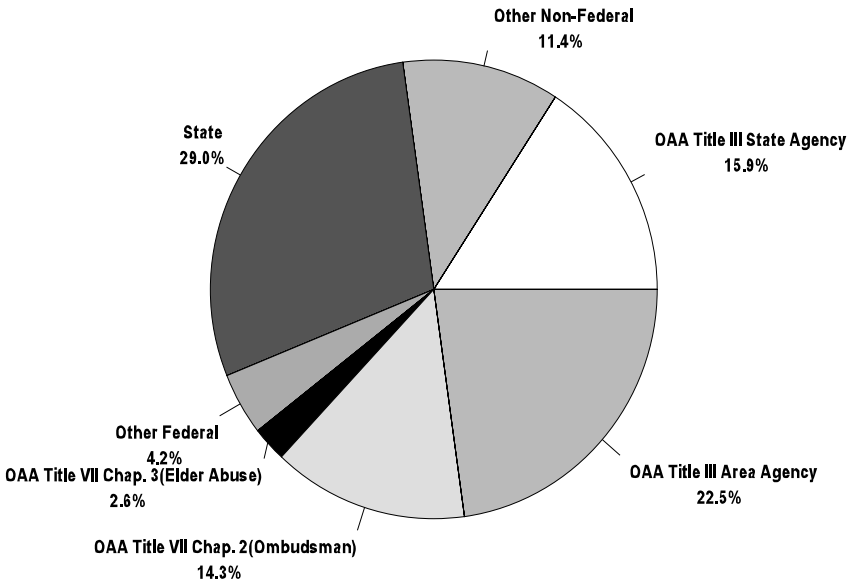
Program Operations

Resources

Total funding from all sources for the Ombudsman Program nationwide was $60,271,594 in FY 2001, an increase of $3.16 million above FY 2000, which was $6.73 million over 1999. The largest proportion of these increases were from state sources. The federal government continued to provide the most program funding in FY 2001 — $35.91 million, about 59.6 percent of total funding. Figure 4 below shows the percentages of funding, by source, for FY 2001.

Tables 7-9 on pages 18-19 show amounts and percentages from all sources for FY 1998-2001.

Figure 4: Sources of Funding for FY 2001
Long-Term Care Ombudsman Program



State and Local Programs

There were 596 local and regional ombudsman programs in FY 2001. As shown in Table 12 on page 21, there was little variation in placement of local programs from 1998 to 2001, and most regional programs continued to be located in area agencies on aging. (The shift of 21 entities from "Other" to "Regional Office of State Ombudsman Program" was simply a shift in organizational designation, not in organization placement.)

Most state long-term care ombudsman programs continued to be physically and organizationally located in the state units on aging, but in FY 2001 programs in 14 states (AK, CO, DC, FL, KS, ME, MI, OR, RI, VA, VT, WA, WI and WY) were either free-standing programs or located in private, non-profit agencies or a larger government ombudsman program. (In FY 2003, FL was moved to the state unit on aging, bringing the total to 13.)

Staff and Volunteers

The number of ombudsman staff increased from 926 full-time equivalents (FTEs) in 1998 to 1,029 FTEs in FY 2001. In every year except 2000, there was a four to six percent increase in staff FTEs.

The number of volunteers who were trained and certified to investigate complaints also increased, from 7,359 in 1998 to 8,442 in 2001. Table 11 on page 21 shows trends in staff and volunteer levels from 1995 through 2001.

Long-Term Care Issues Addressed by State Ombudsmen

Issues advocacy involves ombudsman work on laws, regulations and government policies and actions "that pertain to long-term care facilities and services, and to the health, safety, welfare and rights of residents" (OAA, Section 712 (h)(2). State ombudsmen were asked to describe the priority issues which their program had identified and/or worked on during the reporting period; barriers to resolution; and recommendations for system-wide changes needed to resolve the issue, or how the issue was resolved in their state. Thirty-six state ombudsmen responded to this question in 2001, thirty-nine in 2000, and thirty-five in 1999. State ombudsmen descriptions of these issues, actions they have taken to address them, and recommendations to resolve them are provided on the AoA web site referenced in the table of contents.

The issues that state ombudsmen most frequently report as ones they have identified and worked on include: insufficient numbers of staff to care for residents and lack of staff training. As in previous years, discharge and transfer issues were identified as a problem area by a large number of state ombudsmen. Other issues which state ombudsmen frequently reported that they worked on included: inadequate regulation of assisted living and other non-nursing home facilities, the need for support of the Ombudsman Program, and discharges and transfers due to closure of facilities.

Conclusion

Data from the nationwide Long-Term Care Ombudsman Program from 1998 to 2001 show notable increases in most aspects of ombudsman activity:

- Ombudsmen visited more facilities in FY 2001 than in FY 1998.
- In FY 2001, ombudsmen provided more consultations to both clients and their families and to the staffs of long-term care facilities.
- Ombudsmen handled a higher volume of cases and complaints in FY 2001, while resolving a higher percentage of the complaints they handled.

The ombudsmen achieved these results with only a slightly higher number of paid and volunteer workers. The data suggest that long-term care facility residents, their families and the staff of these facilities are increasingly using ombudsmen to address and resolve issues of patient care, patient rights, quality of care and facility administration. Over a four-year period, the percent of complaints which the Ombudsman Program resolved or partially resolved, to the satisfaction of the resident, increased from 71 in 1998 to 76.7 in 2001. In some ways this is the most significant of the productivity improvements because it reflects the program's impact in assisting individual residents in the institutional long-term care setting as well as its significant work in addressing major issues affecting large numbers of residents and potential residents of long-term care facilities.

PROGRAM DATA TABLES

Table 1: Types of Complainants for Cases Closed for FY 2001

Table 1: Types of Complainants for Cases Closed for FY 2001				
	All Facilities /Settings	Nursing Facilities	Board & Care/Other Similar	Non-Facility Settings
Total Complainants	151,737	122,063	26,665	3,099
Resident	32.89%	34.04%	28.98%	20.94%
Relative/ Friend	23.7%	24.15%	21.32%	26.69%
Non-Relative Guardian, Legal Representative	1.11%	1.09%	1.14%	1.76%
Ombudsman, Ombudsman Volunteer	15.96%	15.52%	19.13%	5.58%
Facility Administration, Staff	17.05%	17.53%	13.82%	26.19.%
Other Medical: Physician/ Staff	1.82%	1.52%	2.86%	4.99%
Other Agency Representative	3.67%	2.96%	6.27%	9.27%
Unknown/ Anonymous	2.21%	1.77%	4.16%	2.49%
Other	1.6%	1.43%	2.32%	2.09%

Table 2: Number of Complaints By Group for Fiscal Year 2001

Groups	Nursing Facilities		Board & Care/Other Similar		Non-Facility Settings
Total Complaints	209,663		50,152		4,454
Residents' Rights	65,372	31.2%	17,143	34.2%	
Resident Care	67,483	32.2%	10,902	21.7%	for non-facility
Quality of Life	41,757	19.9%	12,295	24.5%	
Administration	22,718	10.8%	6,545	13.1%	
Not Against Facility	12,333	5.9%	3,267	6.5%	

Table 3: Percentages of Complaints By Group, FY 1998-2001								
	Nursing Facilities				Board & Care/Other Similar			
Groups	1998	1999	2000	2001	1998	1999	2000	2001
Residents' Rights	32.8%	32.0%	30.5%	31.2%	35.8%	35.3%	34.7%	34.2%
Resident Care	31.5%	32.6%	32.6%	32.2%	20.6%	21.4%	23.0%	21.7%
Quality of Life	19.0%	19.5%	19.5%	19.9%	24.0%	24.1%	22.7%	24.5%
Administration	9.5%	9.9%	11.2%	10.8%	11.7%	12.2%	12.0%	13.1%
Not Against Facility	7.3%	6.0%	6.2%	5.9%	7.9%	7.0%	7.6%	6.5%

Table 4: Complaint Verification & Disposition

	1998	1999	2000	2001
Total Complaints	201,053	215,650	231,889	264,269
Complaints Verified				
Number	138,494	150,286	172,592	198,889
Percent	68.9%	69.7%	74.4%	75.26%
Disposition				
Requires government policy or regulatory change or legislative action to resolve	1.5%	1.7%	0.9%	1.2%
Not resolved to the satisfaction of resident or complainant	6.2%	5.9%	5.1%	5.8%
Withdrawn by resident or complainant	4.0%	3.5%	3.2%	2.7%
Referred to other agency for resolution, and report of final disposition not obtained	6.1%	5.9%	5.3%	5.3%
Referred to other agency for resolution, and other agency failed to act on complaint	1.0%	0.7%	0.8%	0.5%
No action needed or appropriate	10.2%	9.2%	8.1%	7.7%
Partially resolved but some problem remained	16.1%	15.5%	18.5%	18.7%
Resolved to satisfaction of resident or complainant	54.9%	57.6%	58.2%	58.0%

Table 5: Top 20 Complaints by Category for Nursing Facilities

		Complaint Categories	1998			1999			2000			2001		
			Total	%	Rank	Total	%	Rank	Total	%	Rank	Total	%	Rank
Group		**See Table B-1 for Codes**	**163,540**			**172,662**			**186,234**			**209,633**		
F.	41	Call lights, requests for assistance	**7,026**	**4.30%**	**1**	**7,644**	**4.43%**	**1**	**8,676**	**4.66%**	**1**	**10,126**	**4.83%**	**1**
D.	26	Dignity, respect-staff attitudes	**5,710**	**3.49%**	**4**	**6,453**	**3.74%**	**4**	**7,351**	**3.95%**	**4**	**8,838**	**4.22%**	**2**
F.	42	Care plan/resident assessment	**5,242**	**3.21%**	**7**	**6,412**	**3.71%**	**5**	**7,550**	**4.05%**	**3**	**8,572**	**4.09%**	**3**
F.	40	Accidents, improper handling	**6,032**	**3.69%**	**3**	**6,804**	**3.94%**	**3**	**7,675**	**4.12%**	**2**	**7,810**	**3.73%**	**4**
F.	45	Personal hygiene	**6,411**	**3.92%**	**2**	**7,110**	**4.12%**	**2**	**7,279**	**3.91%**	**5**	**7,712**	**3.68%**	**5**
C.	19	Discharge/eviction-planning, notice, procedure	**5,407**	**3.31%**	**6**	**5,455**	**3.16%**	**7**	**5,762**	**3.09%**	**7**	**6,699**	**3.20%**	**6**
M.	97	Shortage of staff	**4,887**	**2.99%**	**8**	**5,740**	**3.32%**	**6**	**6,625**	**3.56%**	**6**	**6,664**	**3.18%**	**7**
J.	71	Menu-quantity, quality, variation, choice	**4,554**	**2.78%**	**9**	**5,063**	**2.93%**	**8**	**5,540**	**2.97%**	**8**	**6,161**	**2.94%**	**8**
F.	44	Medications-administration, organization	**3,885**	**2.38%**	**11**	**4,397**	**2.55%**	**10**	**4,914**	**2.64%**	**9**	**5,734**	**2.74%**	**9**
F.	48	Symptoms unattended, no notice to others of change in condition	**3,818**	**2.33%**	**12**	**4,077**	**2.36%**	**12**	**4,617**	**2.48%**	**10**	**5,075**	**2.42%**	**10**
A.	1	Physical abuse	**5,426**	**3.32%**	**5**	**4,591**	**2.66%**	**9**	**4,350**	**2.34%**	**11**	**4,842**	**2.31%**	**11**
E.	38	Personal property lost, stolen, used by others, destroyed	**3,993**	**2.44%**	**10**	**4,229**	**2.45%**	**11**	**4,227**	**2.27%**	**12**	**4,680**	**2.23%**	**12**
M.	100	Staff unresponsive, unavailable	**3,248**	**1.99%**	**13**	**3,286**	**1.90%**	**15**	**3,700**	**1.99%**	**15**	**4,605**	**2.20%**	**13**
K.	78	Cleanliness, pests	**3,123**	**1.91%**	**14**	**3,458**	**2.00%**	**14**	**3,832**	**2.06%**	**13**	**4,199**	**2.00%**	**14**
D.	27	Exercise choice and/or civil rights	**2,851**	**1.74%**	**15**	**3,479**	**2.01%**	**13**	**3,803**	**2.04%**	**14**	**4,109**	**1.96%**	**15**
M.	101	Supervision	**1,925**	**1.18%**	**27**	**2,325**	**1.35%**	**24**	**3,326**	**1.79%**	**16**	**3,607**	**1.72%**	**16**
A.	6	Resident to resident	**2,577**	**1.58%**	**19**	**2,851**	**1.65%**	**17**	**3,034**	**1.63%**	**18**	**3,569**	**1.70%**	**17**
K.	79	Equipment/building-disrepair, hazard, poor lighting, fire safety	**1,952**	**1.19%**	**26**	**2,541**	**1.47%**	**20**	**2,899**	**1.56%**	**19**	**3,472**	**1.66%**	**18**
F.	49	Toileting	**2,720**	**1.66%**	**16**	**3,022**	**1.75%**	**16**	**3,093**	**1.66%**	**17**	**3,377**	**1.61%**	**19**
K.	83	Odors	**2,493**	**1.52%**	**21**	**2,544**	**1.47%**	**19**	**2,472**	**1.33%**	**24**	**3,230**	**1.54%**	**20**
A.	3	Verbal/mental abuse	**2,598**	**1.59%**	**18**	**2,601**	**1.51%**	**18**	**2,787**	**1.50%**	**20**	**3,171**	**1.51%**	**21**
F.	52	Other: Care	**2,717**	**1.66%**	**17**	**2,521**	**1.46%**	**21**	**2,645**	**1.42%**	**21**	**2,776**	**1.32%**	**22**
E.	36	Billing/charges: notice, approval, questionable, accounting wrong or denied	**2,428**	**1.48%**	**22**	**2,497**	**1.45%**	**22**	**2,589**	**1.39%**	**22**	**2,755**	**1.31%**	**23**
A.	5	Gross neglect	**2,551**	**1.56%**	**20**	**2,331**	**1.35%**	**23**	**2,372**	**1.27%**	**25**	**2,591**	**1.24%**	**25**
P.	122	Legal-guardianship, conservatorship, power of attorney, wills	**2,268**	**1.39%**	**24**	**1,974**	**1.14%**	**28**	**2,309**	**1.24%**	**26**	**2,465**	**1.18%**	**27**

Table 6: Top 20 Complaints by Category for Board and Care Facilities

			1998			1999			2000			2001		
Complaint Categories			Total	%	Rank	Total	%	Rank	Total	%	Rank	Total	%	Rank
Group		**See Table B-1 for Codes**	**34,696**			**37,953**			**41,397**			**50,152**		
J.	71	Menu-quantity, quality, variation, choice	**1,792**	**5.16%**	**1**	**1,816**	**4.78%**	**1**	**2,060**	**4.98%**	**1**	**2,736**	**5.46%**	**1**
F.	44	Medications-administration, organization	**1,433**	**4.13%**	**2**	**1,682**	**4.43%**	**2**	**1,844**	**4.45%**	**2**	**2,234**	**4.45%**	**2**
D.	26	Dignity, respect-staff attitudes	**1,129**	**3.25%**	**4**	**1,336**	**3.52%**	**4**	**1,491**	**3.60%**	**3**	**1,915**	**3.82%**	**3**
C.	19	Discharge/eviction-planning, notice, procedure	**1,216**	**3.50%**	**3**	**1,365**	**3.60%**	**3**	**1,421**	**3.43%**	**4**	**1,691**	**3.37%**	**4**
K.	79	Equipment/building-disrepair, hazard, poor lighting, fire safety	**1,023**	**2.95%**	**6**	**1,300**	**3.43%**	**5**	**1,261**	**3.05%**	**5**	**1,486**	**2.96%**	**5**
K.	78	Cleanliness, pests	**927**	**2.67%**	**8**	**1,133**	**2.99%**	**6**	**1,091**	**2.64%**	**6**	**1,419**	**2.83%**	**6**
F.	45	Personal hygiene	**940**	**2.71%**	**7**	**914**	**2.41%**	**8**	**1,061**	**2.56%**	**7**	**1,163**	**2.32%**	**7**
M.	97	Shortage of staff	**720**	**2.08%**	**12**	**836**	**2.20%**	**12**	**1,001**	**2.42%**	**9**	**1,149**	**2.29%**	**8**
F.	42	Care plan/resident assessment	**664**	**1.91%**	**15**	**754**	**1.99%**	**15**	**1,025**	**2.48%**	**8**	**1,146**	**2.29%**	**9**
E.	38	Personal property lost, stolen, used by others, destroyed	**691**	**1.99%**	**14**	**789**	**2.08%**	**14**	**867**	**2.09%**	**12**	**1,080**	**2.15%**	**10**
E.	36	Billing/charges: notice, approval, questionable, accounting wrong or denied	**724**	**2.09%**	**11**	**825**	**2.17%**	**13**	**928**	**2.24%**	**10**	**1,061**	**2.12%**	**11**
E.	37	Personal funds-mismanaged, access denied, deposits & other money not returned	**887**	**2.56%**	**9**	**929**	**2.45%**	**7**	**806**	**1.95%**	**14**	**1,012**	**2.02%**	**12**
D.	27	Exercise choice and/or civil rights	**644**	**1.86%**	**16**	**719**	**1.89%**	**16**	**701**	**1.69%**	**17**	**1,009**	**2.01%**	**13**
F.	40	Accidents, improper handling	**698**	**2.01%**	**13**	**843**	**2.22%**	**10**	**886**	**2.14%**	**11**	**1,009**	**2.01%**	**13**
A.	1	Physical abuse	**1,044**	**3.01%**	**5**	**901**	**2.37%**	**9**	**847**	**2.05%**	**13**	**979**	**1.95%**	**15**
A.	3	Verbal/mental abuse	**797**	**2.30%**	**10**	**843**	**2.22%**	**10**	**802**	**1.94%**	**15**	**895**	**1.78%**	**16**
F.	48	Symptoms unattended, no notice to others of change in condition	**577**	**1.66%**	**17**	**644**	**1.70%**	**17**	**703**	**1.70%**	**16**	**895**	**1.78%**	**16**
M.	100	Staff unresponsive, unavailable	**465**	**1.34%**	**25**	**533**	**1.40%**	**24**	**552**	**1.33%**	**26**	**859**	**1.71%**	**18**
M.	98	Staff training, lack of screening	**483**	**1.39%**	**24**	**573**	**1.51%**	**20**	**603**	**1.46%**	**20**	**848**	**1.69%**	**19**
A.	5	Gross neglect	**562**	**1.62%**	**18**	**614**	**1.62%**	**18**	**649**	**1.57%**	**18**	**798**	**1.59%**	**20**
K.	77	Air temperature, and quality	**536**	**1.54%**	**20**	**612**	**1.61%**	**19**	**581**	**1.40%**	**21**	**772**	**1.54%**	**22**
L.	93	Offering inappropriate level of care	**518**	**1.49%**	**21**	**534**	**1.41%**	**23**	**520**	**1.26%**	**30**	**731**	**1.46%**	**25**
P.	122	Legal-guardianship, conservatorship, power of attorney, wills	**506**	**1.46%**	**23**	**458**	**1.21%**	**28**	**610**	**1.47%**	**19**	**591**	**1.18%**	**28**
F.	51	Wandering-failure to accommodate/monitor	**539**	**1.55%**	**19**	**557**	**1.47%**	**21**	**542**	**1.31%**	**28**	**569**	**1.13%**	**29**

Table 7: Selected National Information FY 1998 through FY 2001

Category	FY 1998	FY 1999	FY 2000	FY 2001
Total Program Funding	$47,404,557	$51,380,290	$57,109,733	$60,271,594
Local Ombudsman Entities	587	587	591	596
Paid Program Staff (FTEs)	927	974	970	1,029
Volunteers				
Certified Volunteer Ombudsmen[1]	7,359	8,451	8,384	8,442
Other Volunteers	5,645	5,813	5,245	5,258
Total Volunteers	13,004	14,264	13,629	13,700
Licensed Facilities				
Board & Care/Similar[2]	41,292	43,943	43,102	45,723

[1] Individuals who have completed a training course prescribed by the state ombudsman and are approved by the state ombudsman to participate in the Ombudsman Program.

[2] Includes only those types of facilities which state ombudsman programs include within their purview under the requirement of

Table 8: Trends in the Ombudsman Program—FY 1998–2001

	FY 1998	FY 1999	FY 2000	FY 2001
Total Number Local Programs	587	587	591	596
Local Programs in AAA's	366	369	372	372
Total Number Complainants (Cases)	121.7	130.3	137.2	151.7
Total Number Complaints (000s)	201.1	215.7	231.9	264.3
Funding (in millions of dollars)				
Title III-B Funding				
Allotted by State & Area Agencies	20.1	21.3	22.2	23.2
Allotted by State Agencies	11.0	10.0	10.2	9.6
Allotted by Area Agencies	9.1	11.3	12.0	13.6
Title VII Chapter Two	4.5	6.6	7.9	8.6
Title VII, Chapter Three	1.8	1.9	1.6	1.5
All other Federal	1.1	1.7	2.1	2.6
All State	13.2	13.6	15.8	17.5
All Other Non-Federal	6.7	6.3	7.6	6.9
Total Funding	**47.4**	**51.4**	**57.1**	**60.3**

Table 9: Change in Funding: Federal vs. Non-Federal FY1998-FY2001				
	FY 1998	**FY 1999**	**FY 2000**	**FY 2001**
Total Funds (000,000)	47.40	51.38	57.11	60.27
Source of Funds				
Federal (000,000)	27.55	31.48	33.78	35.91
Non-Federal (000,000)	19.85	19.90	23.41	23.36
Federal (%)	58.12	61.26	59.15	59.59
Non-Federal (%)	41.88	38.74	40.85	40.41

Table 10: Designated Local Ombudsman Entities for FY 1998-2001

Year	Total	Area Agency on Aging	Other Local Government Entity	Legal Services Provider	Social Services Non-profit Agency	Freestanding Ombudsman Program	Regional Office of State Ombudsman Program	Other
FY 2001	596	372	14	26	85	12	70	17
FY 2000	591	372	3	28	87	15	48	38
FY 1999	587	369	19	27	80	16	47	29
FY 1998	587	366	18	30	79	18	46	30

Table 11 Ombudsman Program Staff and Volunteers
Totals for FY 1998-2001

	1998	1999	2000	2001
Paid program staff (FTEs)	**927**	**975**	**970**	**1,029**
working at state level	174	181	183	193
working at local level	752	793	787	836
Paid individuals working full-time on program	**679**	**757**	**767**	**839**
at state level	143	155	159	161
at local level	536	602	608	679
Volunteer ombudsmen trained and certified to investigate complaints	**7,359**	**8,451**	**8,384**	**8,442**
working at state level	217	215	301	288
working at local level	7,142	8,236	8,083	8,154
Other Volunteers (supporting roles, not involved in complaint work)	**5,645**	**5,813**	**5,245**	**5,258**
working at state level	66	51	94	56
working at local level	5579	5,762	5,151	5,202

Table 12: Other Ombudsman Activities					
		1998	1999	2000	2001
Percent of all facilities visited not in response to complaints	*nursing homes*	78.3%	83.1%	79.0%	85.4%
	board & care	44.6%	47.2%	44.8%	44.4%
Participation in facility surveys	*surveys:*	9,533	12,215	9,403	10,003
Working with resident and family councils (attendance at meetings)	*resident council meetings:*	18,239	16,631	15,955	14,895
	family council meetings:	5,768	6,367	6,046	4,317
Providing community education	*sessions:*	9,307	10,231	11,567	8,995
Working with the media	*interviews:*	4,015	4,661	5,906	5,811
	press releases issued:	4,755	14,411	15,860	4,388
Providing training and technical assistance to staff and volunteers in the statewide ombudsman program	*training sessions:*	8,847	11,880	11,405	10,001
	hours:	44,235	52,670	47,537	46,050
	ombudsman trainees:	30,717	33,454	39,257	43,591
Providing training and consultation to managers and staff of long-term care facilities	*training sessions:*	7,298	9,260	8,139	8,499
	consultations:	68,066	75,862	94,435	107,602
Providing information and consultation to individuals (usually by telephone)	*consultations:*	209,476	210,276	244,535	282,964

Endnotes

1. In the National Ombudsman Reporting System (NORS) *case* is synonymous with *complainant* and is defined as "each inquiry brought to, or initiated by, the ombudsman on behalf of a resident or group of residents involving one or more complaints or problems which requires opening of a case file and includes ombudsman investigation, fact gathering, setting of objectives and/or strategy to resolve, and follow-up." *Complaint* is defined as "a concern brought to, or initiated by, the ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility relating to health, safety, welfare or rights of a resident. One or more complaints constitute a case."

2. Definition of *verified*: "It is determined after work (interviews, record inspection, observation, etc.) that the circumstances described in the complaint are substantiated or generally accurate." Within the Ombudsman Program it is understood and program instructions state that just because a complaint cannot be verified does not mean that it did not happen or that there is not a problem which requires explanation or resolution.